CHAPTER 7

Prioritizing Client Care: Leadership, Delegation, and Emergency Response Planning

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Priority Concepts

Leadership; Health Care Organizations

I. Health Care Delivery Systems

A. Managed care

1. *Managed care* is a broad term used to describe strategies used in the health care delivery system that reduce the costs of health care.
2. Client care is outcome driven and is managed by a case **management** process.
3. Managed care emphasizes the promotion of health, client education and responsible self-care, early identification of disease, and the use of health care resources.

B. Case management

1. Case management is a health care delivery strategy that supports managed care; it uses an interprofessional health care delivery approach that provides comprehensive client care throughout the client's illness, using available resources to promote high-quality and cost-effective care.
2. Case management includes assessment and development of a plan of care, coordination of all services, referral, and follow-up.
3. Critical pathways are used, and variation analysis is conducted.
4. The core functions of case management are assessment, treatment planning, linking, advocacy, and monitoring.

Case management involves consultation and collaboration with an interprofessional health care team.

C. Case manager

1. A case manager is a professional nurse who assumes responsibility for coordinating the client's care at admission and after discharge.
2. The case manager establishes a plan of care with the client, coordinates any interprofessional consultations and referrals, and facilitates discharge.
3. A case manager is knowledgeable in various types of health insurance, which allows them to assist clients in navigating health care options covered by insurance.

D. Health Insurance

1. There are state and federal insurance plans.
2. An aim of the Affordable Care Act is to reduce the amount of uncompensated care the average U.S. family pays for by requiring everyone to have health insurance or pay a tax penalty. Its goals are to expand access to health insurance, reduce costs, and protect clients against arbitrary actions by insurance companies.
3. There are many insurance companies that provide state marketplace insurance; some include Aetna, Blue Cross Blue Shield, Cigna, Humana, Kaiser, United, and TriCare/Humana.
4. Types of insurance plans include health maintenance organizations (HMOs), preferred provider organizations (PPOs), exclusive provider organizations (EPOs), point-of-service (POS) plans, high-deductible health plans (HDHPs), and health savings accounts (HSAs); these offer varying options in terms of insurance coverage and out-of-pocket costs and premiums.
5. Medicare is a federal health insurance program for persons aged 65 or older, certain younger people with disabilities, and people with end-stage renal disease (ESRD) requiring dialysis or renal transplant. Certain premiums are attached to each part.
    a. Part A: covers hospital stays, skilled nursing facility stays, hospice care, and some home health care
    b. Part B: helps pay for some services not covered by Part A. Medicare usually covers 80% for approved services;

remaining 20% is the client's responsibility and a supplemental insurance needs to be obtained

c. Part C: a health plan offered by a private insurance agency that contracts with Medicare to supplement coverage

d. Part D: covers prescription medication needs

6. Medicaid is a joint federal and state program that provides health benefits to eligible low-income adults, children, pregnant women, elderly individuals, and people with disabilities. A concern associated with these programs is fraud and abuse; a case manager needs to know how to complete insurance, state, and federal applications and be astute enough to know if an individual is reporting incorrect information.

E. Critical pathway

1. A critical pathway is a clinical management care plan for providing client-centered care and for planning and monitoring the client's progress within an established time frame; **interprofessional collaboration** and teamwork ensure shared decision making and quality client care.
2. Critical pathways are based on evidence-based practice and include evidence-based medical practice, budgetary, organizational, and systems-wide information.
3. Variation analysis is a continuous process that the case manager and other caregivers conduct by comparing the specific client outcomes with the expected outcomes described on the critical pathway.
4. The goal of a critical pathway is to anticipate and recognize negative variance (i.e., client problems) early so that appropriate action can be taken and positive client outcomes can result.
5. Critical pathways are used to ensure medical care is consistent within budget constraints and to allow providers to care for more complex clients. For example, some ambulatory practices have critical pathways for certain conditions such as blood pressure monitoring or urinary tract infections.

F. Nursing Care Plan

1. A nursing care plan is a written guideline and communication tool that identifies the client's pertinent assessment data, problems and nursing diagnoses, goals, interventions, and expected outcomes.

2. The plan enhances interprofessional continuity of care by identifying specific nursing actions necessary to achieve the goals of care.
3. The client and family are involved in developing the plan of care, and the plan identifies short-term and long-term goals.
4. Client problems, goals, interventions, and expected outcomes are documented in the care plan, which provides a framework for evaluation of the client's response to nursing actions. The care plan is modified as the client condition changes.

II. Nursing Delivery Systems

A. Functional nursing

1. Functional nursing involves a task approach to client care, with tasks being delegated by the charge nurse to individual members of the team.
2. This type of system is task-oriented, and the team member focuses on the delegated task rather than the total client; this results in fragmentation of care and lack of **accountability** by the team member.

B. Team nursing

1. The team generally is led by a registered nurse (team leader) who is responsible for assessing clients, analyzing client data, planning, and evaluating each client's plan of care.
2. The team leader determines the work assignment; each staff member works fully within the realm of his or her educational and clinical expertise and job description.
3. Each staff member is accountable for client care and outcomes of care delivered in accordance with the licensing and practice scope as determined by health care agency policy and state law.
4. Modular nursing is similar to team nursing but takes into account the structure of the unit; the unit is divided into modules, allowing nurses to care for a group of clients who are geographically close by.

C. Relationship-based practice (primary nursing)

1. Relationship-based practice (primary nursing) is concerned with keeping the nurse at the bedside, actively involved in client care, while planning goal-directed, individualized care.
2. One (primary) nurse is responsible for managing and coordinating the client's care while in the hospital and for discharge, and an associate nurse cares for the client when the primary nurse is off-duty.

D. Client-focused care

1. This is also known as the total care or case method; the

registered nurse assumes total responsibility for planning and delivering care to a client.

2. The client may have different nurses assigned during a 24-hour period; the nurse provides all necessary care needed for the assigned time period.

III. Professional Responsibilities

A. Accountability

1. The process in which individuals have an obligation (or duty) to act and are answerable for their choices, decisions, and actions.
2. Involves assuming only the responsibilities that are within one's scope of practice and not assuming responsibility for activities in which competence has not been achieved.
3. Involves admitting mistakes rather than blaming others and evaluating the outcomes of one's own actions.
4. Includes a responsibility to the client to be competent and provide nursing care in accordance with standards of nursing practice while adhering to the professional ethics codes.

Accountability is the acceptance of responsibility for one's choices, decisions, and actions. The nurse is always responsible for their actions when providing care to a client.

B. **Leadership** and **management**

1. Leadership is the interpersonal process that involves influencing others (followers) to achieve goals.
2. Management is the accomplishment of tasks or goals by oneself or by directing others.

C. Theories of leadership and management (Box 7-1)

D. Leader and manager approaches

1. Authoritarian leadership
    a. The leader or manager is focused and maintains strong control, makes decisions, and addresses all problems.
    b. The leader or manager dominates the group and commands rather than seeks suggestions or input.
2. Democratic leadership
    a. This is also called *participative management*.
    b. It is based on the belief that every group member should have input into

problem solving and the development of goals; leader obtains participation from group and then makes best decision for the organization, based on the input from group.

c. The democratic style is a more "talk with the members" style and much less authoritarian than the autocratic style.

3. Laissez-faire leadership
    a. A laissez-faire leader or manager assumes a passive, nondirective, and inactive approach and relinquishes part or all of the responsibilities to the members of the group.
    b. Decision making is left to the group, with the laissez-faire leader or manager providing little, if any, guidance, support, or feedback.
4. Situational leadership
    a. Situational approach uses a combination of styles based on the current circumstances and events.
    b. Situational styles are assumed according to the needs of the group and the tasks to be achieved.
5. Bureaucratic leadership
    a. The leader or manager believes that individuals are motivated by external forces.
    b. The leader or manager relies on organizational policies and procedures for decision making.
6. Transformational leadership
    a. Focused on building relationships.
    b. Motivates staff members through a shared vision and mission.
    c. Encourages and praises staff members and inspires them to improve performance levels while earning staff respect and loyalty.
7. Servant leadership
    a. Servant leaders influence and motivate others by building relationships and developing the skills of individual team members.
    b. Servant leaders make sure to meet the needs of the individual team members

and to give each person input in decisions.

E. Effective leader and manager behaviors and qualities (Box 7-2)

F. Functions of management (Box 7-3)

G. Problem-solving process and decision making
1. Problem solving involves obtaining information and using it to reach an acceptable solution to a problem.
2. Decision making involves identifying a problem and deciding which alternatives can best achieve objectives.
3. Steps of the problem-solving process are similar to the steps of the nursing process (Table 7-1).

H. Types of managers
1. Front-line manager
   a. Front-line managers function in supervisory roles of those involved with delivery of client care. Front-line managers may temporarily assume a client care role.
   b. Front-line roles usually include charge nurse, team leader, and client care coordinator.
   c. Front-line managers coordinate the activity of all staff who provide client care and supervise team members during the manager's period of accountability.
2. Middle manager
   a. Middle manager roles usually include unit manager and supervisor.
   b. A middle manager's responsibilities may include supervising staff, preparing budgets, preparing work schedules, writing and implementing policies that guide client care and unit operations, and maintaining the quality of client services.
3. Nurse executive
   a. The nurse executive is a top-level nurse manager and may be the director of nursing services or the vice president for client care services that assists with carrying out the mission of a health care organization.
   b. The nurse executive supervises numerous departments and works closely with the administrative team of

the organization to ensure that nursing staff provide optimal client care.

c. The nurse executive ensures that all client care provided by nurses is consistent with the objectives of the health care organization.

IV. Power

A. Power is the ability to influence others and control their actions to achieve desired results.

B. Powerful people are able to modify behavior and influence others to change, even when others are resistant to change.

C. Powerful people are change agents that lead or create positive change to support or maintain high-quality care and decrease adverse effects.

D. Effective nurse leaders use power to improve the delivery of care and to enhance the profession.

E. There are different types of power (Box 7-4).

V. Empowerment

A. Empowerment is an interpersonal process of enabling others to do for themselves.

B. Empowerment occurs when individuals are able to influence what happens to them more effectively.

C. Empowerment involves open communication, mutual goal setting, and shared decision making.

D. Nurses can empower clients and others through teaching and **advocacy**.

VI. Formal Organizations

A. An organization's mission statement communicates in broad terms its reason for existence and the attitudes, beliefs, and values by which the organization functions.

B. Goals and objectives are measurable activities specific to the development of designated services and programs of an organization.

C. The organizational chart depicts and communicates how activities are arranged, how authority relationships are defined, and how communication channels are established.

D. Policies, procedures, and protocols

1. Policies are guidelines that define the organization's directives on courses of action.
2. Procedures are based on policy and define methods for tasks.
3. Protocols prescribe a specific course of action for a specific type of client or problem.

a. Centralization is the making of decisions by a few individuals at the

top of the organization or by managers of a department or unit, and decisions are communicated thereafter to the employees.

b. Decentralization is the distribution of authority throughout the organization to allow for increased responsibility and **delegation** in decision making; decentralization tries to move the decision making as close to the client as possible.

The nurse must follow policies, procedures, and protocols of the health care agency in which he or she is employed.

VII. **Evidence-Based Practice**

A. Research is an important role of the professional nurse. Research provides a foundation for improvement in nursing practice.

B. Evidence-based practice is an approach to client care in which the nurse integrates the client's preferences, clinical expertise, and the best research evidence to deliver quality care.

C. Determining the client's personal, social, cultural, and religious preferences ensures individualization and is a component of implementing evidence-based practice.

D. The nurse needs to be an observer and identify and question situations that require change or result in a less than desirable outcome.

E. Use of information technology such as online resources, including research publications, provides current research findings related to areas of practice.

F. The nurse needs to follow evidence-based practice protocols developed by the institution and question the rationale for nursing approaches identified in the protocols as necessary. The nurse should use appropriate evaluation criteria when determining areas in need of research (Table 7-2).

Evidence-based practice requires that the nurse base nursing practice on the best and most applicable evidence from clinical research studies. The nurse should also be alert to clinical issues that warrant investigation and develop a researchable question about the problem.

VIII. Quality Improvement

A. Also known as performance improvement, quality improvement focuses on processes or systems that significantly contribute to

client safety and effective client care outcomes; criteria are used to monitor outcomes of care and to determine the need for change to improve the quality of care.

B. Quality improvement processes or systems may be named quality assurance, continuous quality management, or continuous quality improvement.

C. When quality improvement is part of the philosophy of a health care agency, every staff member becomes involved in ways to improve client care and outcomes.

D. A retrospective ("looking back") audit is an evaluation method used to inspect the medical record after the client's discharge for documentation of compliance with the standards.

E. A concurrent ("at the same time") audit is an evaluation method used to inspect compliance of nurses with predetermined standards and criteria while the nurses are providing care during the client's stay.

F. Peer review is a process in which nurses employed in an organization evaluate the quality of nursing care delivered to the client.

G. The quality improvement process is similar to the nursing process and involves an interprofessional approach.

H. An outcome describes the response to care; comparison of client responses with the expected outcomes indicates whether the interventions are effective, whether the client has progressed, how well standards are met, and whether changes are necessary.

I. The nurse is responsible for recognizing trends in nursing practice, identifying recurrent problems, and initiating opportunities to improve the quality of care.

Quality improvement processes improve the quality of care delivery to clients and the safety of health care agencies.

IX. Change Process

A. Change is a dynamic process that leads to an alteration in behavior.

B. A change agent can be used to effectively facilitate change. Change agents appropriately assess and manage the reactions of staff members. They can connect and balance all aspects of the organization that will be affected by change.

C. Leadership style influences the approach to initiating the change process.

D. Lewin's basic concept of the change process includes 3 elements for successful change: unfreezing, moving and changing, and refreezing (Fig. 7-1).

1. Unfreezing is the first phase of the process, during which the problem is identified and individuals involved gather facts and evidence supporting a basis

for change.
2. During the moving and changing phase, change is planned and implemented.
3. Refreezing is the last phase of the process, during which the change becomes stabilized.

E. Types of change
1. Planned change: A deliberate effort to improve a situation
2. Unplanned change: A reactive response that is required because of a disruption. The change is beneficial and may go unnoticed.

F. Resistance to change (Box 7-5)
1. Resistance to change occurs when an individual rejects proposed new ideas without critically thinking about the proposal.
2. Change requires energy.
3. The change process does not guarantee positive outcomes.

G. Overcoming barriers
1. Create a flexible and adaptable environment.
2. Encourage the people involved to plan and set goals for change.
3. Include all involved in the plan for change.
4. Focus on the benefits of the change in relation to improvement of client care.
5. Delineate the drawbacks from failing to make the change in relation to client care.
6. Evaluate the change process on an ongoing basis and keep everyone informed of progress.
7. Provide positive feedback to all involved.
8. Commit to the time it takes to change.

X. Conflict

A. Conflict is an internal or external friction that arises from a perception of incompatibility or difference in beliefs, attitudes, values, goals, priorities, or decisions.

B. Types of conflict
1. Intrapersonal: Occurs within a person
2. Interpersonal: Occurs between and among clients, nurses, or other staff members
3. Organizational: Occurs when an employee confronts the policies and procedures of the organization

C. Modes of conflict resolution

1. Avoidance
a. Avoiders are unassertive and uncooperative.
b. Avoiders do not pursue their own needs, goals, or concerns, and they do

not assist others to pursue theirs.
c. Avoiders postpone dealing with the issue.

2. Accommodation
   a. Accommodators neglect their own needs, goals, or concerns (unassertive) while trying to satisfy those of others.
   b. Accommodators obey and serve others and often feel resentment and disappointment because they "get nothing in return."
3. Competition
   a. Competitors pursue their own needs and goals at the expense of others.
   b. Competitors also may stand up for rights and defend important principles.
4. Compromise
   a. Compromisers are assertive and cooperative.
   b. Compromisers work creatively and openly to find the solution that most fully satisfies all important objectives and goals to be achieved.

XI. Roles of Health Care Team Members

A. Nurse roles are as follows:
1. Promote health and prevent disease
2. Provide comfort and care to clients
3. Make decisions
4. Act as client advocate
5. Lead and manage the nursing team
6. Serve as case manager
7. Function as a rehabilitator
8. Communicate effectively
9. Educate clients, families, and communities and health care team members
10. Act as a resource person
11. Allocate resources in a cost-effective manner

B. Primary health care provider (PHCP): A PHCP or specialist diagnoses and treats disease.

C. Physician's assistant
1. A physician's assistant (PA) acts to a limited extent in the role of the physician during the physician's absence.
2. The PA conducts physical examinations, performs diagnostic procedures, assists in the operating room and emergency department, and performs treatments.

3. Certified and licensed PAs in some states have prescriptive powers.

D. Nurse practitioner: an advanced practice registered nurse (APRN) who is educated to diagnose and treat acute illness and chronic conditions; health promotion and maintenance is a focus.
   1. An APRN may work in a variety of specialty areas including family practice, internal medicine, acute gerontology, women's health or obstetrics, acute care, pediatrics, or other specialty areas.
   2. APRNs have independent practice authority in most states.

E. Physical therapist: A physical therapist assists in examining, testing, and treating clients recuperating from injuries, illness, or surgery and physically disabled clients.

F. Occupational therapist: An occupational therapist develops adaptive devices that help chronically ill clients or clients with a disability perform activities of daily living.

G. Respiratory therapist: A respiratory therapist delivers treatments designed to improve the client's ventilation and oxygenation status.

H. Speech therapist: A speech therapist evaluates a client's ability to swallow safely and evaluates speech and communication ability. The speech therapist develops a plan to treat communication and swallowing disorders. These therapists also work to prevent, assess, diagnose, and treat speech, language, social communication, and cognitive communication in children and adults.

I. Nutritionist: A nutritionist or dietitian assists in planning dietary measures to improve or maintain a client's nutritional status.

J. Continuing care nurse: This nurse coordinates discharge plans for the client.

K. Assistive personnel, help the registered nurse with specified tasks and functions.

L. Pharmacist: A pharmacist formulates and dispenses medications.

M. Social worker: A social worker counsels clients and families about home care services and assists the continuing care nurse with planning and facilitating discharge.

N. Chaplain: A chaplain (or trained layperson) offers spiritual support and guidance to clients and families.

O. Administrative staff: Administrative or support staff members organize and schedule diagnostic tests and procedures and arrange for services needed by the client and family.

XII. **Interprofessional Collaboration**

A. Client care planning can be accomplished through referrals, consultations, or interprofessional collaborations with other health care specialists and through client care conferences, which involve members from all health care disciplines. This approach helps ensure continuity of care.

B. Reports

1. Reports should be factual, accurate, current, complete, and organized.
2. Reports should include essential background information, subjective data, objective data, any changes in the client's status, client problems or nursing diagnoses as appropriate, treatments and procedures, medication administration, client teaching, discharge planning, family information, the client's response to treatments and procedures, and the client's priority needs.
3. Change-of-shift (handoff) report
    a. The report facilitates continuity of care among nurses who are responsible for a client.
    b. The report may be written, oral, audiotaped, or provided during walking rounds at the client's bedside.
    c. The report describes the client's health status and informs the nurse who assumes care about the client's needs and priorities for care.
    d. The report may be done at the client's bedside to allow the client to participate in care planning, as well as to establish the stability of the client before the oncoming nurse assumes care.
4. Telephone reports
    a. Purposes include informing a PHCP of a client's change in status, communicating information about a client's transfer to or from another unit or facility, and obtaining results of laboratory or diagnostic tests.
    b. The telephone report should be documented and should include when the call was made, who made the call, who was called, to whom information was given, what information was given, and what information was received.
5. Transfer reports
    a. Transferring nurse reports provide continuity of care and may be given by telephone or in person (Box 7-6).
    b. Receiving nurse should repeat transfer

information to ensure client safety and ask questions to clarify information about the client's status.

6. Situation, Background, Assessment, Recommendation (SBAR)
    a. SBAR, a communication model, is a structured and standardized communication technique that improves communication among team members when sharing information on a client.
    b. SBAR includes up-to-date information about the client's situation, associated background information, assessment data, and recommendations for care, such as treatments, medications, or services needed.
    c. Refer to Chapter 12 for SOAP (subjective, objective, assessment, plan) notes

XIII. Interprofessional Consultation

A. Consultation is a process in which a specialist is sought to identify methods of care or treatment plans to meet the needs of a client.

B. Consultation is needed when the nurse encounters a problem that cannot be solved using nursing knowledge, skills, and available resources.

C. Consultation also is needed when the exact problem remains unclear; a consultant can objectively and more clearly assess and identify the exact nature of the problem.

D. Rapid-response teams are being developed within hospitals to provide nursing staff with internal consultative services provided by expert clinicians.

E. Rapid-response teams are used to assist nursing staff with early detection and resolution of client problems.

F. Rapid-response teams are also teams of health care providers that respond to hospitalized clients with early signs of deterioration on non–intensive care units to prevent respiratory or cardiac arrest.

G. Medication reconciliation includes collaboration among the client, PHCPs, nurses, and pharmacists to ensure medication accuracy when clients experience changes in health care settings or levels of care or are transferred from one care unit to another, and upon discharge (Box 7-7).

XIV. Discharge Planning

A. Discharge planning begins when the client is admitted to the hospital or health care facility.

B. Discharge planning is an interprofessional process that ensures

that the client has a plan for continuing care after leaving the health care facility and assists in the client's transition from one environment to another.

C. All caregivers need to be involved in discharge planning, and referrals to other PHCPs or agencies may be needed. A PHCP's prescription may be needed for the referral, and the referral needs to be approved by the client's health care insurer.

D. The nurse should anticipate the client's discharge needs and make the required referral as soon as possible (involving the client and family in the referral process).

E. The nurse needs to educate the client and family regarding care at home (Box 7-8).

XV. **Delegation** and Assignments

A. Delegation

1. Delegation is a process of transferring performance of a selected nursing task in a situation to an individual who is competent and has the authority to perform that specific task.
2. Delegation involves achieving outcomes and sharing activities with other individuals who have the authority to accomplish the task.
3. The nurse practice act and any practice limitations (institutional policies and procedures, and job descriptions of personnel provided by the institution) define which aspects of care can be delegated and which must be performed by a registered nurse.
4. Even though a task may be delegated to someone, the nurse who delegates maintains ultimate accountability for the task.
5. The nurse cannot delegate any activity that involves nursing judgment or critical decision making.
6. The 5 rights of delegation include the right task, right circumstances, right person, right direction/communication, and right supervision/evaluation.

The nurse delegates only tasks for which he or she is responsible. The nurse who delegates is accountable for the task; the person who assumes responsibility for the task is also accountable.

B. Principles and guidelines of delegating (Box 7-9)

C. Assignments

1. Assignment is the transfer of performance of client care activities to specific staff members.
2. Guidelines for client care assignments
    a. Always ensure client safety.

b. Be aware of individual variations in work abilities.
c. Determine which tasks can be delegated and to whom.
d. Match the task to the delegatee on the basis of the nurse practice act and any practice limitations (institutional policies and procedures, and job descriptions of personnel provided by the institution).
e. Provide directions that are clear, concise, accurate, and complete.
f. Validate the delegatee's understanding of the directions.
g. Communicate a feeling of confidence to the delegatee, and provide feedback promptly after the task is performed.
h. Maintain continuity of care as much as possible when assigning client care.

XVI. Time Management

A. Description

1. Time management is a technique designed to assist in completing tasks within a definite time period.
2. Learning how, when, and where to use one's time and establishing personal goals and time frames are part of time management.
3. Time management requires an ability to anticipate the day's activities, to combine activities when possible, and to not be interrupted by nonessential activities.
4. Time management involves efficiency in completing tasks as quickly as possible and effectiveness in deciding on the most important task to do (i.e., **prioritizing**) and doing it correctly.

B. Principles and guidelines

1. Identify tasks, obligations, and activities and write them down.
2. Organize the workday; identify which tasks must be completed in specified time frames.
3. Prioritize client needs according to importance.
4. Anticipate the needs of the day and provide time for unexpected and unplanned tasks that may arise.
5. Focus on beginning the daily tasks, working on the most important first while keeping goals in mind; look at the final goal for the day to help break down tasks into manageable parts.
6. Begin client rounds at the beginning of the shift, collecting data on each assigned client.

7. Delegate tasks when appropriate.
8. Keep a daily hour-by-hour log to assist in providing structure to the tasks that must be accomplished, and cross tasks off the list as they are accomplished.
9. Use health care agency resources wisely, anticipating resource needs, and gather the necessary supplies before beginning the task.
10. Organize paperwork and continuously document task completion and necessary client data throughout the day (i.e., documentation should be concurrent with completion of a task or observation of pertinent client data).
11. At the end of the day, evaluate the effectiveness of time management.

XVII. Prioritizing Care

A. Prioritizing is deciding which needs or problems require immediate action and which ones could tolerate a delay in response until a later time because they are not urgent.
B. Guidelines for prioritizing (Box 7-10)
C. Setting priorities for client teaching
1. Determine the client's immediate learning needs.
2. Identify the type of learning needs for the individual; for example, consider the client's age, cognitive age, language needs, and generational concerns.
3. Review the learning objectives established for the client.
4. Determine what the client perceives as important.
5. Assess the client's anxiety level and the time available to teach.
D. Prioritizing when caring for a group of clients
1. Identify the problems of each client.
2. Review the problems and any nursing diagnoses.
3. Determine which client problems are most urgent based on basic needs, the client's changing or unstable status, and complexity of the client's problems.
4. Anticipate the time that it may take to care for the priority needs of the clients.
5. Combine activities, if possible, to resolve more than one problem at a time.
6. Involve the client in his or her care as much as possible (see Priority Nursing Actions).

Use the ABCs—airway, breathing, and circulation—Maslow's Hierarchy of Needs theory, and the steps of the nursing process

(assessment is first) to prioritize. Also consider the acuity level of clients when applying these guidelines. If cardiopulmonary resuscitation (CPR) needs to be initiated, use CAB—compressions, airway, breathing—as the priority guideline.

Priority Nursing Actions

Assessing a Group of Clients in Order of Priority

The nurse is assigned to the following clients. The order of priority in assessing the clients is as follows:

1. A client with heart failure who has a 4-lb weight gain since yesterday and is experiencing shortness of breath
2. A 24-hour postoperative client who had a wedge resection of the lung and has a closed chest tube drainage system
3. A client admitted to the hospital for observation who has absent bowel sounds
4. A client who is undergoing surgery for a hysterectomy on the following day

References

Potter et al. (2017), pp. 284-285
Zerwekh, Zerwekh Garneau (2015), pp. 511, 514.

XVIII. **Disasters** and **Emergency Response Planning**

A. Description

1. A disaster is any human-made or natural event that causes destruction and devastation that cannot be alleviated without assistance (Box 7-11).
2. Internal disasters are disasters that occur within a health care agency (e.g., health care agency fire, structural collapse, radiation spill), whereas external disasters are disasters that occur outside the health care agency (e.g., mass transit accident that could send hundreds of victims to emergency departments).
3. A **multicasualty event** involves a limited number of victims or casualties and can be managed by a hospital with available resources; a **mass casualty event** involves a number of casualties that exceeds the resource capabilities of the hospital, and is also known as a disaster.
4. An emergency response plan is a formal plan of action for coordinating the response of the health care agency staff in the event of a disaster in the health care agency or surrounding community.

B. American Red Cross (ARC)

1. The ARC has been given authority by the federal government to provide disaster relief.
2. All ARC disaster relief assistance is free, and local offices are located across the United States.

3. The ARC participates with the government in developing and testing community disaster plans.
4. The ARC identifies and trains personnel for emergency response.
5. The ARC works with businesses and labor organizations to identify resources and individuals for disaster work.
6. The ARC educates the public about ways to prepare for a disaster.
7. The ARC operates shelters, provides assistance to meet immediate emergency needs, and provides disaster health services, including crisis counseling.
8. The ARC handles inquiries from family members.
9. The ARC coordinates relief activities with other agencies.
10. Nurses are involved directly with the ARC and assume functions such as managers, supervisors, and educators of first aid; they also participate in emergency response plans and disaster relief programs and provide services, such as blood collection drives and immunization programs.

C. HAZMAT (hazardous materials) team
1. HAZMAT teams are typically composed of emergency department health care providers and nursing staff, because they will be the first individuals to encounter the potential exposure.
2. Members of HAZMAT teams have been educated on how to recognize patterns of illness that may be indicative of nuclear, biological, and chemical exposure; protocols for pharmacological treatment of infectious disease agents; availability of decontamination facilities and personal protective gear; safety measures; and the methods of responding to an exposure.

D. Phases of disaster management
1. The Federal Emergency Management Agency (FEMA) identifies 4 disaster management phases: mitigation, preparedness, response, and recovery.
2. Mitigation encompasses the following:
    a. Actions or measures that can prevent the occurrence of a disaster or reduce the damaging effects of a disaster
    b. Determination of the community hazards and community risks (actual and potential threats) before a disaster occurs
    c. Awareness of available community resources and community health

personnel to facilitate mobilization of activities and minimize chaos and confusion if a disaster occurs

d. Determination of the resources available for care to infants, older adults, disabled individuals, and individuals with chronic health problems

3. Preparedness encompasses the following:
    a. Plans for rescue, evacuation, and caring for disaster victims
    b. Plans for training disaster personnel and gathering resources, equipment, and other materials needed for dealing with the disaster
    c. Identification of specific responsibilities for various emergency response personnel
    d. Establishment of a community emergency response plan and an effective public communication system
    e. Development of an emergency medical system and a plan for activation
    f. Verification of proper functioning of emergency equipment
    g. Collection of anticipatory provisions and creation of a location for providing food, water, clothing, shelter, other supplies, and needed medicine
    h. Inventory of supplies on a regular basis and replenishment of outdated supplies
    i. Practice of community emergency response plans (mock disaster drills)
4. Response encompasses the following:
    a. Putting disaster planning services into action and the actions taken to save lives and prevent further damage
    b. Primary concerns include safety and the physical and mental health of victims and members of the disaster response team
5. Recovery encompasses the following:
    a. Actions taken to return to a normal situation after the disaster
    b. Preventing debilitating effects and restoring personal, economic, and environmental health and stability to

the community

E. Levels of disaster
   1. FEMA identifies three levels of disaster with FEMA response (Box 7-12).
   2. When a federal emergency has been declared, the federal response plan may take effect and activate emergency support functions.
   3. The emergency support functions of the ARC include performing emergency first aid, sheltering, feeding, providing a disaster welfare information system, and coordinating bulk distribution of emergency relief supplies.
   4. Disaster medical assistant teams (teams of specially trained personnel) can be activated and sent to a disaster site to provide triage and medical care to victims until they can be evacuated to a hospital.

F. Nurse's role in disaster planning
   1. Personal and professional preparedness
      a. Make personal and family preparations (Box 7-13).
      b. Be aware of the disaster plan at the place of employment and in the community.
      c. Maintain certification in disaster training and in CPR.
      d. Participate in mock disaster drills, including bomb threat and active shooter drills.
      e. Prepare professional emergency response items, such as a copy of nursing license, personal health care equipment such as a stethoscope, cash, warm clothing, recordkeeping materials, and other nursing care supplies.
   2. Disaster response
      a. In the health care agency setting, if a disaster occurs, the agency disaster preparedness plan (emergency response plan) is activated immediately, and the nurse responds by following the directions identified in the plan.
      b. In the community setting, if the nurse is the first responder to a disaster, the nurse cares for the victims by attending to the victims with life-

threatening problems first; when rescue workers arrive at the scene, immediate plans for triage should begin.

In the event of a disaster, activate the emergency response plan immediately.

G. **Triage**

1. In a disaster or war, triage consists of a brief assessment of victims that allows the nurse to classify victims according to the severity of the injury, urgency of treatment, and place for treatment (see Priority Nursing Actions).

Priority Nursing Actions

Triaging Victims at the Site of an Accident

The nurse is the first responder at the scene of a school bus accident. The nurse triages the victims from highest to lowest priority as follows:

1. Confused child with bright red blood pulsating from a leg wound
2. Child with a closed head wound and multiple compound fractures of the arms and legs
3. Child with a simple fracture of the arm complaining of arm pain
4. Sobbing child with several minor lacerations on the face, arms, and legs

Reference

Ignatavicius. Workman, Rebar. 2018;151–152.

2. Simple Triage and Rapid Treatment (START) is a strategy used to evaluate the severity of injury of each victim as quickly as possible and tag the victims in about 30 to 60 seconds.
3. In an emergency department, triage consists of a brief assessment of clients that allows the nurse to classify clients according to their need for care and establish priorities of care; the type of illness or injury, the severity of the problem, and the resources available govern the process.

H. Emergency department triage system

1. A commonly used rating system in an emergency department is a 3-tier system that uses the categories of emergent, urgent, and nonurgent; these categories may be identified by color coding or

numbers (Box 7-14).

2. The nurse needs to be familiar with the triage system of the health care agency.
3. When caring for a client who has died, the nurse needs to recognize the importance of family and cultural and religious rituals and provide support to loved ones.
4. Organ donation procedures of the health care agency need to be addressed if appropriate.

Think survivability. If you are the first responder to a scene of a disaster, such as a train crash, a priority victim is one whose life can be saved.

I. Client assessment in the emergency department

1. Primary assessment
    a. The purpose of primary assessment is to identify any client problem that poses an immediate or potential threat to life.
    b. The nurse gathers information primarily through objective data and, on finding any abnormalities, immediately initiates interventions.
    c. The nurse uses the ABCs—airway, breathing, and circulation—as a guide in assessing a client's needs and assesses a client who has sustained a traumatic injury for signs of a head injury or cervical spine injury. If CPR needs to be initiated, use CAB—compressions, airway, breathing—as the priority guideline.
    d. Agonal breathing does not provide effective respiration and ventilation and indicates a need for ventilatory support.
    e. Only central pulses, such as the carotid or femoral pulses, should be used to assess circulation; they should be checked for at least 5 seconds but no longer than 10 seconds so as to not delay chest compressions.
2. Secondary assessment
    a. The nurse performs secondary assessment after the primary assessment and after treatment for any primary problems identified.
    b. Secondary assessment identifies any other life-threatening problems that a client might be experiencing.
    c. The nurse obtains subjective and objective data, including a history, general overview, vital sign measurements, neurological assessment, pain assessment, and complete or focused physical assessment.

Box 7-1

Theories of Leadership and Management

Charismatic: Based on personal beliefs and characteristics of influence
Quantum: Based on the concepts of chaos theory; maintaining a balance between tension and order prevents an unstable environment and promotes creativity
Relational: Based on collaboration and teamwork
Servant: Based on a desire to serve others; the leader emerges when another's needs assume priority
Shared: Based on the belief that several individuals share the responsibility for achieving the health care agency's goals
Transactional: Based on the principles of social exchange theory
Transformational: Based on the individual's commitment to the health care agency's vision; focuses on promoting change

Box 7-2

Effective Leader and Manager Behaviors and Qualities

Behaviors

Treats followers as unique individuals
Inspires followers and stimulates critical thinking
Shows followers how to think about old problems in new ways and assists with adapting to change
Is visible to followers; is flexible; and provides guidance, assistance, and feedback
Communicates a vision, establishes trust, and empowers followers
Motivates followers to achieve goals

Qualities

Effective communicator; promotes interprofessional collaboration
Credible
Critical thinker
Initiator of action
Risk taker
Is persuasive and influences employees

Adapted from Huber D: *Leadership and nursing care management*, ed 5, Philadelphia, 2014, Saunders.

Box 7-3

Functions of Management

Planning: Determining objectives and identifying methods that lead to achievement of objectives
Organizing: Using resources (human and material) to achieve predetermined outcomes
Directing: Guiding and motivating others to meet expected outcomes
Controlling: Using performance standards as criteria for measuring success and taking corrective action

Table 7-1

Similarities of the Problem-Solving Process and the Nursing Process

Problem-Solving Process	Nursing Process
Identifying a problem and collecting data about the problem	Assessment
Determining the exact nature of the problem	Analysis (Diagnosis)
Deciding on a plan of action	Planning
Carrying out the plan	Implementation
Evaluating the plan	Evaluation

Box 7-4

Types of Power

Reward: Ability to provide incentives
Coercive: Ability to punish
Referent: Based on attraction, loyalty, and respect
Expert: Based on having an expert knowledge foundation and skill level
Legitimate: Based on a position in society
Personal: Derived from a high degree of self-confidence
Informational: When one person provides explanations why another should behave in a certain way

Table 7-2

Evaluation Criteria for Evidence for Clinical Questions

Level	Definition
Level I	Evidence comes from a review of a number of randomized controlled trials (RCTs) or from clinical practice guidelines that are based on such a review.
Level II	Evidence comes from at least one well-designed RCT.
Level III	Evidence comes from well-designed controlled studies that are not randomized.
Level IV	Evidence comes from well-designed case-controlled and cohort studies.
Level	Evidence comes from a number of descriptive or qualitative studies.

V	
Level VI	Evidence comes from a single descriptive or qualitative study.
Level VII	Evidence comes from the opinion of authorities and/or reports of expert committees.

From Zerwekh J, Zerwekh Garneau A: *Nursing today: transition and trends*, ed 8, Philadelphia, 2015, Saunders. Data from Sackett D et al.: *Evidence-based medicine: how to practice and teach EBM*, London, 2000, Churchill Livingstone.

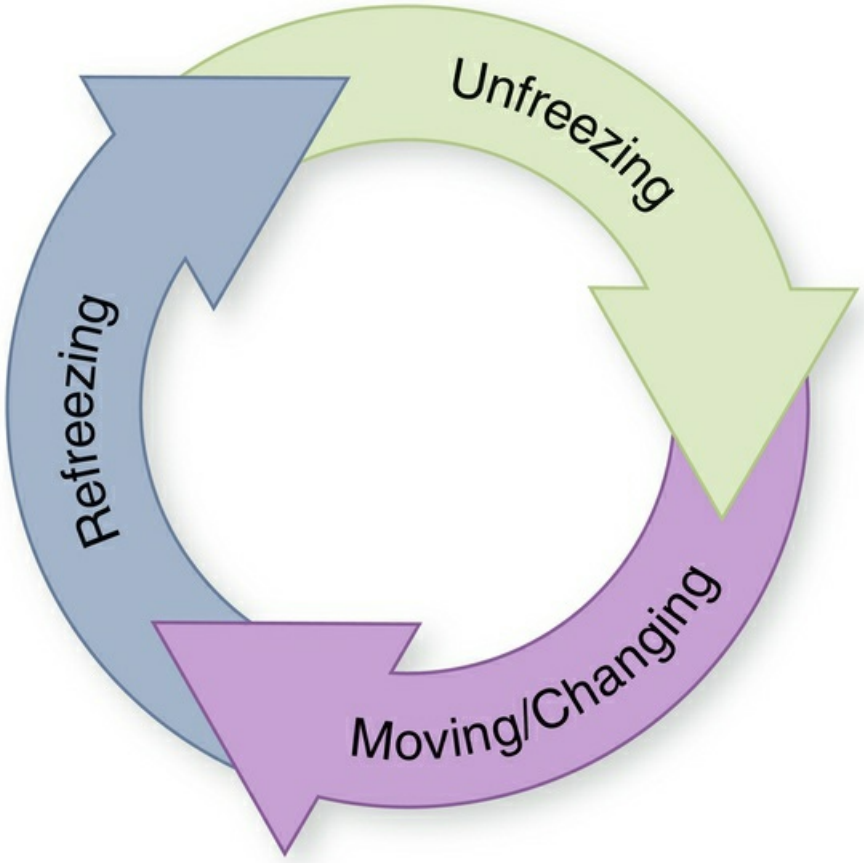

FIG. 7-1 Elements of a successful change.

Box 7-5

Reasons for Resisting Change

Conformity

One goes along with others to avoid conflict.

Dissimilar Beliefs and Values

Differences can impede positive change.

Habit

Routine, set behaviors are often hard to change.

Secondary Gains

Benefits or payoff are present, so there is no incentive to change.

Threats to Satisfying Basic Needs

Change may be perceived as a threat to self-esteem, security, or survival.

Fear

One fears failure or has fear of the unknown.

Box 7-6

Transfer Reports

- Client's name, age, health care provider, and diagnoses
- Current health status and plan of care
- Client's needs and priorities for care
- Any assessments or interventions that need to be performed after transfer, such as laboratory tests, medication administration, or dressing changes
- Need for any special equipment
- Additional considerations such as allergies, resuscitation status, precautionary considerations, cultural or religious issues, or family issues

Box 7-7

Process for Medication Reconciliation

1. Obtain a list of current medications from the client.
2. Develop an accurate list of newly prescribed medications.
3. Compare new medications to the list of current medications.
4. Identify and investigate any discrepancies and collaborate with the health care provider as necessary.
5. Communicate the finalized list with the client, caregivers, primary health care provider, and other team members.

From Potter P, Perry A, Stockert P, Hall A: *Fundamentals of nursing*, ed 8, St. Louis, 2013, Mosby.

Box 7-8

Discharge Teaching

- How to administer prescribed medications
- Side and adverse effects of medications that need to be reported to the primary health care provider (PHCP)
- Prescribed dietary and activity measures
- Complications of the medical condition that need to be reported to the PHCP
- How to perform prescribed treatments
- How to use special equipment prescribed for the client
- Schedule for home care services that are planned
- How to access available community resources
- When to obtain follow-up care

Box 7-9

Principles and Guidelines of Delegating

- Delegate the right task to the right delegatee. Be familiar with the experience of the delegatees, their scopes of practice, their job descriptions, agency policy and procedures, and the state nurse practice act.
- Provide clear directions about the task and ensure that the delegatee understands the expectations.
- Determine the degree of supervision that may be required.
- Provide the delegatee with the authority to complete the task; provide a deadline for completion of the task.
- Evaluate the outcome of care that has been delegated.
- Provide feedback to the delegatee regarding his or her performance.
- *In general,* noninvasive interventions, such as skin care, range-of-motion exercises, ambulation, grooming, and hygiene measures, can be assigned to the assistive personnel (AP).
- *In general,* a licensed practical nurse (LPN) or vocational nurse (VN) can perform not only the tasks that an AP can perform, but also certain invasive tasks, such as dressing changes, suctioning, urinary catheterization, and medication administration (oral, subcutaneous, intramuscular, and selected piggyback medications), according to the education and job description of the LPN or VN. The LPN or VN can data collect and also review with the client teaching plans that were initiated by the registered nurse.
- A registered nurse (RN) can perform the tasks that an LPN or VN can perform and is responsible for assessment and planning care, initiating teaching, and administering medications intravenously.
- An RN can care for stable and unstable clients.
- An LPN or VN cares for stable clients.

- An AP provides basic care that does not require any type of assessment; they can perform routine tasks in client care.

Box 7-10

Guidelines for Prioritizing

- The nurse and the client mutually rank the client's needs in order of importance based on the client's preferences and expectations, safety, and physical and psychological needs; what the client sees as his or her priority needs may be different from what the nurse sees as the priority needs.
- Priorities are classified as high, intermediate, or low.
- Client needs that are life-threatening or that could result in harm to the client if they are left untreated are high priorities.
- Nonemergency and non–life-threatening client needs are intermediate priorities.
- Client needs that are not related directly to the client's illness or prognosis are low priorities.
- The nurse can use the ABCs—airway, breathing, and circulation—as a guide when determining priorities; client needs related to maintaining a patent airway are always the priority.
- If cardiopulmonary resuscitation (CPR) is necessary, the order of priority is CAB—compressions, airway, and breathing—this is the exception to using the ABCs when determining priorities.
- When providing care, the nurse needs to decide which needs or problems require immediate action and which ones could be delayed until a later time because they are not urgent.
- The nurse considers client problems that involve actual or life-threatening concerns before potential health-threatening concerns.
- The nurse can use Maslow's Hierarchy of Needs theory as a guide to determine priorities and to identify the levels of physiological needs, safety, love and belonging, self-esteem, and self-actualization (basic needs are met before moving to other needs in the hierarchy).
- When prioritizing care, the nurse must consider time constraints and available resources.
- Problems identified as important by the client must be given high priority.
- The nurse can use the steps of the nursing process as a guide to determine priorities, remembering that assessment is the first step of the nursing process.
- Prioritization may be different in a disaster or emergency situation, where an action should be taken before gathering further information.

Box 7-11

Types of Disasters

Human-Made Disasters

Dam failures resulting in flooding
Hazardous substance accidents such as pollution, chemical spills, or toxic gas leaks
Accidents involving release of radioactive material
Resource shortages such as food, water, and electricity
Structural collapse, fire, or explosions
Terrorist attacks such as bombing, riots, and bioterrorism
Mass transportation accidents

Natural Disasters

Avalanches
Blizzards
Communicable disease epidemics
Cyclones
Droughts
Earthquakes
Floods
Forest fires
Hailstorms
Hurricanes
Landslides
Mudslides
Tidal waves
Tornadoes
Volcanic eruptions

Box 7-12

Federal Emergency Management Agency (FEMA) Levels of Disaster

Level I Disaster

Massive disaster that involves significant damage and results in a presidential disaster declaration, with major federal involvement and full engagement of federal, regional, and national resources

Level II Disaster

Moderate disaster that is likely to result in a presidential declaration of an emergency, with moderate federal assistance

Level III Disaster

Minor disaster that involves a minimal level of damage but could result in a presidential declaration of an emergency

Box 7-13

Emergency Plans and Supplies

- Plan a meeting place for family members.
- Identify where to go if an evacuation is necessary.
- Determine when and how to turn off water, gas, and electricity at main switches.
- Locate the safe spots in the home for each type of disaster.
- Replace stored water supply every 3 months and stored food supply every 6 months.
- Include the following supplies:
    - Backpack, clean clothing, sturdy footwear
    - Pocket knife or multi-tool
    - A 3-day supply of water (1 gallon per person per day)
    - A 3-day supply of nonperishable food
    - Blankets/sleeping bags/pillows
    - First-aid kit with over-the-counter medications and vitamins
    - Adequate supply of prescription medication
    - Battery-operated radio
    - Flashlight and batteries
    - Credit card, cash, or traveler's checks
    - Personal ID card, list of emergency contacts, allergies, medical information, list of credit card numbers and bank accounts (all sealed in a water-tight package)
    - Extra set of car keys and a full tank of gas in the car
    - Sanitation supplies for washing, toileting, and disposing of trash; hand sanitizer
    - Extra pair of eyeglasses/sunglasses
    - Special items for infants, older adults, or disabled individuals
    - Items needed for a pet such as food, water, and leash
    - Paper, pens, pencils, maps
    - Cell phone
    - Work gloves
    - Rain gear
    - Roll of duct tape and plastic sheeting
    - Radio and extra batteries
    - Toiletries (basic daily needs, sunscreen, insect repellent, toilet paper)
    - Plastic garbage bags and resealable bags
    - Household bleach for disinfection
    - Whistle
    - Matches in a waterproof container

From Ignatavicius D, Workman M: *Medical surgical nursing: patient-centered collaborative care*, ed 7, Philadelphia, 2013, Saunders.

Box 7-14

Emergency Department Triage

Emergent (Red): Priority 1 (Highest)

This classification is assigned to clients who have life-threatening injuries and need immediate attention and continuous evaluation but have a high probability for survival when stabilized.

Such clients include trauma victims, clients with chest pain, clients with severe respiratory distress or cardiac arrest, clients with limb amputation, clients with acute neurological deficits, and clients who have sustained chemical splashes to the eyes.

Urgent (Yellow): Priority 2

This classification is assigned to clients who require treatment and whose injuries have complications that are not life-threatening, provided that they are treated within 30 minutes to 2 hours; these clients require continuous evaluation every 30 to 60 minutes thereafter.

Such clients include clients with an open fracture with a distal pulse and large wounds.

Nonurgent (Green): Priority 3

This classification is assigned to clients with local injuries who do not have immediate complications and who can wait at least 2 hours for medical treatment; these clients require evaluation every 1 to 2 hours thereafter.

Such clients include clients with conditions such as a closed fracture, minor lacerations, sprains, strains, or contusions.

Note: Some triage systems include tagging a client "Black" if the victim is dead or soon will be deceased because of severe injuries; these are victims that would not benefit from any care because of the severity of injuries.

From Ignatavicius D, Workman M: *Medical surgical nursing: patient-centered collaborative care*, ed 7, Philadelphia, 2013, Saunders.

Practice Questions

29. The nurse is assigned to care for four clients. In planning client rounds, which client should the nurse assess **first?**
    1. A postoperative client preparing for discharge with a new medication
    2. A client requiring daily dressing changes of a recent surgical incision
    3. A client scheduled for a chest x-ray after insertion of a nasogastric tube
    4. A client with asthma who requested a breathing treatment during the previous shift

30. The nurse employed in an emergency department is assigned to triage clients coming to the emergency department for treatment on the evening shift. The nurse should assign **priority** to which client?
    1. A client complaining of muscle aches, a headache, and history of seizures
    2. A client who twisted her ankle when rollerblading and is requesting medication for pain
    3. A client with a minor laceration on the index finger sustained while cutting an eggplant
    4. A client with chest pain who states that he just ate pizza that was made with a very spicy sauce
31. A nursing graduate is attending an agency orientation regarding the nursing model of practice implemented in the health care facility. The nurse is told that the nursing model is a team nursing approach. The nurse determines that which scenario is characteristic of the team-based model of nursing practice?
    1. Each staff member is assigned a specific task for a group of clients.
    2. A staff member is assigned to determine the client's needs at home and begin discharge planning.
    3. A single registered nurse (RN) is responsible for providing care to a group of 6 clients with the aid of an assistive personnel (AP).
    4. An RN leads 2 licensed practical nurses (LPNs) and 3 APs in providing care to a group of 12 clients.
32. The nurse has received the assignment for the day shift. After making initial rounds and checking all of the assigned clients, which client should the nurse plan to care for **first?**
    1. A client who is ambulatory demonstrating steady gait
    2. A postoperative client who has just received an opioid pain medication
    3. A client scheduled for physical therapy for the first crutch-walking session
    4. A client with a white blood cell count of 14,000 mm^3 (14×10^9/L) and a temperature of 38.4° C
33. The nurse is giving a bed bath to an assigned client when an assistive personnel (AP) enters the client's room and tells the nurse that another assigned client is in pain and needs pain medication. Which is the **most appropriate** nursing action?
    1. Finish the bed bath and then administer the pain medication to the other client.
    2. Ask the AP to find out when the last pain medication was given to the client.
    3. Ask the AP to tell the client in pain that medication will be administered as soon as the bed bath is complete.
    4. Cover the client, raise the side rails, tell the client that you will return shortly, and administer the pain medication to the other client.
34. The nurse manager has implemented a change in the method of the nursing delivery system from functional to team nursing. An assistive personnel (AP)

is resistant to the change and is not taking an active part in facilitating the process of change. Which is the **best** approach in dealing with the AP?

1. Ignore the resistance.
2. Exert coercion on the AP.
3. Provide a positive reward system for the AP.
4. Confront the AP to encourage verbalization of feelings regarding the change.

35. The registered nurse is planning the client assignments for the day. Which is the **most appropriate** assignment for an assistive personnel (AP)?
    1. A client requiring a colostomy irrigation
    2. A client receiving continuous tube feedings
    3. A client who requires urine specimen collections
    4. A client with difficulty swallowing food and fluids
36. The nurse manager is discussing the facility protocol in the event of a tornado with the staff. Which instructions should the nurse manager include in the discussion? **Select all that apply.**
    - ☐ 1. Open doors to client rooms.
    - ☐ 2. Move beds away from windows.
    - ☐ 3. Close window shades and curtains.
    - ☐ 4. Place blankets over clients who are confined to bed.
    - ☐ 5. Relocate ambulatory clients from the hallways back into their rooms.
37. The nurse employed in a long-term care facility is planning assignments for the clients on a nursing unit. The nurse needs to assign four clients and has a licensed practical nurse and 3 assistive personnel (APs) on a nursing team. Which client would the nurse **most appropriately** assign to the licensed practical nurse?
    1. A client who requires a bed bath
    2. An older client requiring frequent ambulation
    3. A client who requires hourly vital sign measurements
    4. A client requiring abdominal wound irrigations and dressing changes every 3 hours
38. The charge nurse is planning the assignment for the day. Which factors should the nurse remain mindful of when planning the assignment? **Select all that apply.**
    - ☐ 1. The acuity level of the clients
    - ☐ 2. Specific requests from the staff
    - ☐ 3. The clustering of the rooms on the unit
    - ☐ 4. The number of anticipated client discharges
    - ☐ 5. Client needs and workers' needs and abilities

Answers

29. ***Answer:*** 4

Rationale: Airway is always the highest priority, and the nurse would attend to the client with asthma who requested a breathing treatment during the previous shift. This could indicate that the client was experiencing difficulty breathing. The clients described in options 1, 2, and 3 have needs that would be identified as intermediate priorities.

Test-Taking Strategy: Note the **strategic word,** *first.* Use the **ABCs—airway, breathing, and circulation**—to answer the question. Remember that airway is always the highest priority. This will direct you to the correct option.

Level of Cognitive Ability: Analyzing
Client Needs: Safe and Effective Care Environment
Integrated Process: Nursing Process—Planning
Content Area: Leadership/Management: Prioritizing
Health Problem: N/A
Priority Concepts: Care Coordination; Clinical Judgment
References: Potter et al. (2017), pp. 284-285, 1287.

30. ***Answer:*** 4

Rationale: In an emergency department, triage involves brief client assessment to classify clients according to their need for care and includes establishing priorities of care. The type of illness or injury, the severity of the problem, and the resources available govern the process. Clients with trauma, chest pain, severe respiratory distress or cardiac arrest, limb amputation, and acute neurological deficits and those who have sustained chemical splashes to the eyes are classified as emergent and are the highest priority. Clients with conditions such as a simple fracture, asthma without respiratory distress, fever, hypertension, abdominal pain, or a renal stone have urgent needs and are classified as a second priority. Clients with conditions such as a minor laceration, sprain, or cold symptoms are classified as nonurgent and are a third priority.

Test-Taking Strategy: Note the **strategic word,** *priority.* Use the **ABCs—airway, breathing, and circulation**—to direct you to the correct option. A client experiencing chest pain is always classified as priority 1 until a myocardial infarction has been ruled out.

Level of Cognitive Ability: Analyzing
Client Needs: Safe and Effective Care Environment
Integrated Process: Nursing Process—Assessment
Content Area: Leadership/Management: Prioritizing
Health Problem: N/A
Priority Concepts: Care Coordination; Clinical Judgment
Reference: Ignatavicius, Workman, Rebar (2018), pp. 123-124.

31. ***Answer:*** 4

Rationale: In team nursing, nursing personnel are led by a registered nurse leader in providing care to a group of clients. Option 1 identifies functional nursing. Option 2 identifies a component of case management. Option 3 identifies primary nursing (relationship-based practice).

Test-Taking Strategy: Focus on the **subject,** team nursing. Keep this **subject** in mind and select the option that best describes a team approach. The correct option is the only one that identifies the concept of a team approach.

Level of Cognitive Ability: Applying
Client Needs: Safe and Effective Care Environment
Integrated Process: Nursing Process—Planning
Content Area: Leadership/Management: Delegating/Supervising
Health Problem: N/A
Priority Concepts: Care Coordination; Collaboration
Reference: Yoder-Wise (2015), pp. 236-237.

32. ***Answer:*** 4

Rationale: The nurse should plan to care for the client who has an elevated white blood cell count and a fever first, because this client's needs are the priority. The client who is ambulatory with steady gait and the client scheduled for physical therapy for a crutch-walking session do not have priority needs. Waiting for pain medication to take effect before providing care to the postoperative client is best.

Test-Taking Strategy: Note the **strategic word,** *first,* and use principles related to prioritizing. Recalling the normal white blood cell count is 5000 to 10,000 mm^3 (5 to 10×10^9/L) and the normal temperature range 97.5° F to 98.6° F (36.4° C to 37° C) will direct you to the correct option.

Level of Cognitive Ability: Analyzing
Client Needs: Safe and Effective Care Environment
Integrated Process: Nursing Process—Planning
Content Area: Leadership/Management: Prioritizing
Health Problem: N/A
Priority Concepts: Care Coordination; Clinical Judgment
References: Potter et al. (2017), pp. 284-285.

33. ***Answer:*** 4

Rationale: The nurse is responsible for the care provided to assigned clients. The appropriate action in this situation is to provide safety to the client who is receiving the bed bath and prepare to administer the pain medication. Options 1 and 3 delay the administration of medication to the client in pain. Option 2 is not a responsibility of the AP.

Test-Taking Strategy: Note the **strategic words,** *most appropriate,* and use principles related to priorities of care. Options 1 and 3 are **comparable or alike** and delay the administration of pain medication, and option 2 is not a responsibility of the AP. The most appropriate action is to plan to administer the medication.

Level of Cognitive Ability: Applying
Client Needs: Safe and Effective Care Environment

Integrated Process: Nursing Process—Implementation
Content Area: Leadership/Management: Prioritizing
Health Problem: N/A
Priority Concepts: Care Coordination; Clinical Judgment
Reference: Potter et al. (2017), pp. 284-285, 382.

34. ***Answer:*** 4

Rationale: Confrontation is an important strategy to meet resistance head-on. Face-to-face meetings to confront the issue at hand will allow verbalization of feelings, identification of problems and issues, and development of strategies to solve the problem. Option 1 will not address the problem. Option 2 may produce additional resistance. Option 3 may provide a temporary solution to the resistance but will not address the concern specifically.

Test-Taking Strategy: Note the **strategic word,** *best.* Options 1 and 2 can be eliminated first because of the words *ignore* in option 1 and *coercion* in option 2. From the remaining options, select the correct option over option 3 because the correct option specifically addresses problem-solving measures.

Level of Cognitive Ability: Applying
Client Needs: Safe and Effective Care Environment
Integrated Process: Nursing Process—Implementation
Content Area: Leadership/Management: Ethical/Legal
Health Problem: N/A
Priority Concepts: Leadership; Professional Identity
Reference: Zerwekh, Zerwekh Garneau (2015), pp. 230, 233.

35. ***Answer:*** 3

Rationale: The nurse must determine the most appropriate assignment based on the skills of the staff member and the needs of the client. In this case, the most appropriate assignment for the AP would be to care for the client who requires urine specimen collections. The AP is skilled in this procedure. Colostomy irrigations and tube feedings are not performed by APs because these are invasive procedures. The client with difficulty swallowing food and fluids is at risk for aspiration.

Test-Taking Strategy: Note the **strategic words,** *most appropriate,* and note the **subject,** an assignment to the AP. Eliminate option 4 first because of the words *difficulty swallowing.* Next, eliminate options 1 and 2 because they are **comparable or alike** and are both invasive procedures and as such an AP cannot perform these procedures.

Level of Cognitive Ability: Creating
Client Needs: Safe and Effective Care Environment
Integrated Process: Nursing Process—Planning
Content Area: Leadership/Management: Delegating/Supervising
Health Problem: N/A
Priority Concepts: Care Coordination; Clinical Judgment
References: Ignatavicius, Workman, Rebar (2018), p. 6.

36. ***Answer:*** 2, 3, 4

Rationale: In this weather event, the appropriate nursing actions focus on protecting clients from flying debris or glass. The nurse should close doors to each client's room and move beds away from windows, and close window shades and curtains to protect clients, visitors, and staff from shattering glass and flying debris. Blankets should be placed over clients confined to bed. Ambulatory clients should be moved into the hallways from their rooms, away from windows.

Test-Taking Strategy: Focus on the **subject,** protecting the client in the event of a tornado. Visualize each of the actions in the options to determine whether these actions would assist in protecting the client and preventing an accident or injury.

Level of Cognitive Ability: Applying
Client Needs: Safe and Effective Care Environment
Integrated Process: Nursing Process—Implementation
Content Area: Leadership/Management: Management of Care
Health Problem: N/A
Priority Concepts: Leadership; Professional Identity
Reference: Potter et al. (2017), pp. 381, 394.

37. ***Answer:*** 4

Rationale: When delegating nursing assignments, the nurse needs to consider the skills and educational level of the nursing staff. Giving a bed bath, assisting with frequent ambulation, and taking vital signs can be provided most appropriately by an AP. The licensed practical nurse is skilled in wound irrigations and dressing changes and most appropriately would be assigned to the client who needs this care.

Test-Taking Strategy: Focus on the **subject,** assignment to a licensed practical nurse, and note the **strategic words,** *most appropriately.* Recall that education and job position as described by the nurse practice act and employee guidelines need to be considered when delegating activities and making assignments. Options 1, 2, and 3 can be eliminated because they are noninvasive tasks that the AP can perform.

Level of Cognitive Ability: Creating
Client Needs: Safe and Effective Care Environment
Integrated Process: Nursing Process—Planning
Content Area: Leadership/Management: Delegating/Supervising
Health Problem: N/A
Priority Concepts: Care Coordination; Clinical Judgment
Reference: Potter et al. (2017), pp. 287-288.

38. ***Answer:*** 1, 5

Rationale: There are guidelines that the nurse should use when delegating and planning assignments. These include the following: ensure client safety; be aware of individual variations in work abilities; determine which tasks can be delegated and to whom; match the task to the delegatee on the basis of the nurse practice act and appropriate position descriptions; provide directions that are clear, concise, accurate, and complete; validate the delegatee's understanding of the directions; communicate

a feeling of confidence to the delegatee and provide feedback promptly after the task is performed; and maintain continuity of care as much as possible when assigning client care. Staff requests, convenience as in clustering client rooms, and anticipated changes in unit census are not specific guidelines to use when delegating and planning assignments.

Test-Taking Strategy: Focus on the **subject,** guidelines to use when delegating and planning assignments. Read each option carefully and use **Maslow's Hierarchy of Needs theory.** Note that the correct options directly relate to the client's needs and client safety.

Level of Cognitive Ability: Applying
Client Needs: Safe and Effective Care Environment
Integrated Process: Nursing Process—Planning
Content Area: Leadership/Management: Delegating/Supervising
Health Problem: N/A
Priority Concepts: Clinical Judgment; Professionalism
References: Potter et al. (2017), p. 288.